FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011551

Facility Name: Medina Nursing Center

Address: P.O. Box 538 (Number) Durand (City) 61024 (Zip Code)

County: Winnebago

Telephone Number: (815) 248-2151 **Fax #** (815) 248-2771

IDPA ID Number: 366125769001

Date of Initial License for Current Owners: 05/18/65

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Holgeir Oksnevad
(Title) Administrator

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,574	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,574	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	536	222	2,472	3,230	8
9	SNF/PED					9
10	ICF	17,554	6,595		24,149	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,090	6,817	2,472	27,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.05%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 89 and days of care provided 2,472

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	211,230	25,041	6,058	242,329		242,329		242,329			1
2	Food Purchase		172,587		172,587		172,587	(8,495)	164,092			2
3	Housekeeping	79,830	20,582		100,412		100,412		100,412			3
4	Laundry	64,328	14,834		79,162		79,162		79,162			4
5	Heat and Other Utilities			76,630	76,630		76,630		76,630			5
6	Maintenance	40,337	17,422	50,692	108,451		108,451		108,451			6
7	Other (specify):*											7
8	**TOTAL General Services**	395,725	250,466	133,380	779,571		779,571	(8,495)	771,076			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	935,932	65,393	211,898	1,213,223		1,213,223		1,213,223			10
10a	Therapy		958	176,617	177,575		177,575		177,575			10a
11	Activities	49,726	3,956	9,151	62,833		62,833		62,833			11
12	Social Services	64,555		7,358	71,913		71,913		71,913			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,050,213	70,307	411,024	1,531,544		1,531,544		1,531,544			16
	C. General Administration											
17	Administrative	118,066			118,066		118,066		118,066			17
18	Directors Fees											18
19	Professional Services			86,283	86,283		86,283	(5,051)	81,232			19
20	Dues, Fees, Subscriptions & Promotions			10,915	10,915		10,915		10,915			20
21	Clerical & General Office Expenses	58,230	26,196	8,484	92,910		92,910	(880)	92,030			21
22	Employee Benefits & Payroll Taxes			277,822	277,822		277,822	(5,634)	272,188			22
23	Inservice Training & Education			1,983	1,983		1,983		1,983			23
24	Travel and Seminar			14,169	14,169		14,169	(2,054)	12,115			24
25	Other Admin. Staff Transportation			5,433	5,433		5,433	877	6,310			25
26	Insurance-Prop.Liab.Malpractice			23,167	23,167		23,167		23,167			26
27	Other (specify):*											27
28	**TOTAL General Administration**	176,296	26,196	428,256	630,748		630,748	(12,742)	618,006			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,622,234	346,969	972,660	2,941,863		2,941,863	(21,237)	2,920,626			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Medina Nursing Center #0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			69,164	69,164		69,164	17,748	86,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,712	1,712		1,712	633	2,345			32
33	Real Estate Taxes			39,678	39,678		39,678		39,678			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles			2,853	2,853		2,853	(877)	1,976			35
36	Other (specify):*											36
37	**TOTAL Ownership**			149,407	149,407		149,407	(18,496)	130,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			134	134		134		134			38
39	Ancillary Service Centers		54,472	2,085	56,557		56,557		56,557			39
40	Barber and Beauty Shops	10,567	554		11,121		11,121		11,121			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,862	48,862		48,862		48,862			42
43	Other (specify):* Nonallowable Costs			27,336	27,336		27,336	(27,336)				43
44	**TOTAL Special Cost Centers**	10,567	55,026	78,417	144,010		144,010	(27,336)	116,674			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,632,801	401,995	1,200,484	3,235,280		3,235,280	(67,069)	3,168,211			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,495)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	216	30		9
10	Interest and Other Investment Income	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,741)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,525)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(25,689)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,259)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(17,810)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,810)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,069)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other Non-Allowable Expenses

Non-allowable expenses	Amount	Reference
To Disallow Vending Machine Supply	($5,919)	43
To Disallow Laboratory Expense	($3,683)	43
To Disallow Radiology Expense	($1,405)	43
To Disallow Insurance	($1,063)	43
To Disallow Travel & Seminar Expense	($2,054)	24
To offset Uniform Sales	($5,634)	22
To offset Misc Income	($880)	21
To Disallow 2003 Legal Fees	($5,051)	19
	($25,689)	

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,495)	0	0	0	0	0	0	0	0	0	0	(8,495)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,495)	0	0	0	0	0	0	0	0	0	0	(8,495)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,495)	0	0	0	0	0	0	0	0	0	0	(8,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	216	17,532	0	0	0	0	0	0	0	0	0	17,748	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	658	0	0	0	0	0	0	0	0	0	633	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,000)	0	0	0	0	0	0	0	0	0	(36,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	191	(17,810)	0	0	0	0	0	0	0	0	0	(17,619)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,266)	0	0	0	0	0	0	0	0	0	0	(15,266)	43
44	**TOTAL Special Cost Centers**	(15,266)	0	0	0	0	0	0	0	0	0	0	(15,266)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,570)	(17,810)	0	0	0	0	0	0	0	0	0	(41,380)	45

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Holgeir J. Oksnevad	100			Medina Manor Building, Inc.	Durand	Lessor
				Owner Johs Oksnevad is the father of Holgeir Oksnevad		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	30	Depreciation		Medina Manor Building, Inc.		17,532	17,532	2
3	V	32	Interest		Medina Manor Building, Inc.		658	658	3
4	V	34	Rent	36,000	Medina Manor Building, Inc.			(36,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,000			$ 18,190	$ * (17,810)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Holgeir Oksnevad	President	Administrator	100.00	None	55	100.00	Salary	$ 115,780	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 115,780		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5					N/A					5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	M&I Dealer Finance		X	Vehicle Loan	$920.60	2/22/2004	$ 55,236	$ 41,560	2/22/09	0.0399	$ 658	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$920.60		$ 55,236	$ 41,560			$ 658	9
	B. Non-Facility Related*											
10									Miscellaneous Interest		1,687	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,687	14
15	TOTALS (line 9+line14)						$ 55,236	$ 41,560			$ 2,345	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 39,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 38,678	2
3. Under or (over) accrual (line 2 minus line 1).		$ (322)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 39,678	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	31,868	8
	2000	35,002	9
	2001	36,424	10
	2002	37,512	11
	2003	38,678	12

2004 Estimated Tax	38,678
Estimated Tax Increase	1.03
Total	39,838
Use	40,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0011551

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-15-251-001	Medina Manor Building	$ 806.20	$ 806.20
2.	05-15-251-002	Medina Manor Building	$ 37,048.00	$ 37,048.00
3.	05-15-251-003	Medina Manor Building	$ 823.86	$ 823.86
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,678.06	$ 38,678.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resistar Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

Medina Manor Apartments
Retirement Apartments
22 units
20,000 Sq. ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	7 acres	1965	$ 3,048	1
2					2
3	TOTALS			$ 3,048	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1965	1965	$ 488,644	$	30	$	$	$ 488,644	4
5	25		1980	1980	158,173		30	5,272	5,272	131,961	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1968	675		15			675	9
10	Building Improvements			1974	861		10			861	10
11	Building Improvements			1975	1,547		10			1,547	11
12	Building Improvements			1976	345		9			345	12
13	Building Improvements			1977	12,614		21			12,614	13
14	Building Improvements			1977	2,793		8			2,793	14
15	Building Improvements			1979	2,620		7			2,620	15
16	Building Improvements			1980	24,465		20			24,465	16
17	Building Improvements			1980	2,137		7			2,137	17
18	Building Improvements			1981	20,211		15			20,211	18
19	Building Improvements			1982	2,305		20			2,305	19
20	Building Improvements			1983	705		5			705	20
21	Building Improvements			1985	980		10			980	21
22	Building Improvements			1985	3,091	103	20	155	52	3,019	22
23	Building Improvements			1986	17,543		10			17,543	23
24	Building Improvements			1987	56,373		20	2,819	2,819	49,323	24
25	Building Improvements			1988	14,212	950	20	711	(239)	11,724	25
26	Building Improvements			1989	30,063	2,004	20	1,503	(501)	23,298	26
27	Building Improvements			1990	1,601	107	20	80	(27)	1,164	27
28	Building Improvements			1991	51,619	3,441	20	2,581	(860)	34,843	28
29	Building Improvements			1991	11,626		20	581	581	7,265	29
30	Building Improvements			1992	39,070	2,605	20	1,954	(651)	22,469	30
31	Building Improvements			1992	3,295	203	20	165	(38)	2,060	31
32	Building Improvements			1992	19,372		20	969	969	12,110	32
33	Building Improvements			1992	23,809	2,362	20	1,190	(1,172)	14,875	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1993	$ 37,059	$ 2,471	20	$ 1,853	$ (618)	$ 21,312	37
38	Building Improvements	1993	100,000		20	5,000	5,000	56,669	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	28,299	39
40	Building Improvements	1994	15,610		10	1,561	1,561	15,610	40
41	Building Improvements	1995	47,826	3,188	15	3,188		30,287	41
42	Building Improvements	1995	36,144	2,410	15	2,410		22,894	42
43	Outdoor Signs	1996	2,149	143	15	143		1,216	43
44	Backflow Preventors	1996	3,679	245	15	245		2,083	44
45	Garbage Disposal	1996	761	51	15	51		433	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		1,267	46
47	Door	1997	1,996	133	15	133		998	47
48	Sign	1997	666	44	15	44		331	48
49	Air Conditioner	1997	3,500	233	15	233		1,748	49
50	Lights	1997	621	41	15	41		308	50
51	Driveway	1997	2,875	192	15	192		1,440	51
52	Fire Alarm	1997	1,246	83	15	83		623	52
53	Plumbing	1997	5,122	341	15	341		2,558	53
54	Telephone System	1997	1,152	77	15	77		553	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		293	55
56	Office Remodeling	1998	2,454	164	15	164		1,066	56
57	Exterior Doors	1998	7,652	510	15	510		3,315	57
58	Windows	1998	15,536	1,036	15	1,036		6,734	58
59	Roof Repair	1998	2,317	154	15	154		1,001	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		1,370	60
61	Fire Alarm	1998	1,157	77	15	77		501	61
62	Telephone System	1998	1,467	98	15	98		635	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,341,920	$ 27,101		$ 38,728	$ 11,627	$ 1,096,100	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,341,920	$ 27,101		$ 38,728	$ 11,627	$ 1,096,100	1
2	Blinds	1999	3,689	246	15	246		1,351	2
3	Window Replacement	1999	5,145	305	15	343	38	1,887	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	521	40	2,866	4
5	Floor Tile	1999	1,049	70	15	70		385	5
6	Air Conditioning	1999	1,895	126	15	126		693	6
7	Boiler	1999	535	35	15	35		193	7
8	Sidewalk	2000	1,386	92	15	92		414	8
9	Kickplates	2000	608	40	15	40		180	9
10	Landscaping Brick	2000	1,139	76	15	76		342	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		3,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		385	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		864	13
14	Stone Wall	2001	1,665	111	15	111		388	14
15	Video Surveillance	2002	14,865	991	15	991		2,478	15
16	Wrought Iron Fence	2002	5,105	340	15	340		850	16
17	Nurses Call System	2002	12,726	848	15	848		2,120	17
18	Custom Doors	2002	9,427	628	15	628		1,570	18
19	Windows Framing	2003	11,656	777	15	777		1,166	19
20	Roof	2003	7,470	498	15	498		747	20
21	Alarm Installation	2003	12,730	849	15	849		1,273	21
22	Cabinets	2004	504	17	15	17		17	22
23	Surveillance Cameras	2004	578	19	15	19		19	23
24	Time Clock	2004	10,000	333	15	333		333	24
25	Latches	2004	8,923	297	15	297		297	25
26	Exhaust Hood	2004	4,290	143	15	143		143	26
27	Bath Call Light	2004	1,229	41	15	41		41	27
28	Ventilator	2004	1,038	35	15	35		35	28
29	Driveway	2004	4,000	133	15	133		133	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,491,746	$ 35,989		$ 47,694	$ 11,705	$ 1,120,770	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 219,763	$ 22,466	$ 23,206	$ 740	10 years	$ 162,043	71
72	Current Year Purchases	49,546	3,040	3,040		10 years	3,040	72
73	Fully Depreciated Assets	20,975					20,975	73
74								74
75	TOTALS	$ 290,284	$ 25,506	$ 26,246	$ 740		$ 186,058	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activity Bus	1975 Ford Bus	1985	$ 9,409	$	$	$	3	$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008				3	18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705				5	49,705	78
79	From Schedule 13A			104,725	12,972	12,972		5	36,852	79
80	TOTALS			$ 181,847	$ 12,972	$ 12,972	$		$ 113,974	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,966,925	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 74,467	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,912	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,445	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,420,802	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Medina Nursing Center
Provider #: 0011551
01/01/04 to 12/31/04 **Schedule 13A**

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Maintenance	1997 Dodge Pick-up	2000	23,705	4,741	4,741	0	5	21,335
Administrative	2002 Jeep Liberty	2002	30,000	4,286	4,286	0	5	11,572
Maintenance	2004 F250 Ford Pickup	2004	51,020	3,945	3,945	0	5	3,945
TOTAL			$104,725	$12,972	$12,972	$0		$36,852

SEE ACCOUNTANTS' COMPILATION REPORT

Cell: Q12
Comment: Lori Silverman:

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/2005	$
13.	12/2006	$
14.	12/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2000 BMW	$ 984.97	$ 1,976	17
18					18
19					19
20					20
21	TOTAL		$ 984.97	$ 1,976	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,293	$ 71,055	$	2,293	$ 71,055	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,054	31,569		1,054	31,569	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2 & C3	hrs		1,442	73,993	958	1,442	74,951	4
5	Physician Care		visits							5
6	Dental Care	L39, C3	visits			2,085			2,085	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				54,472		54,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	4,789	$ 178,702	$ 55,430	4,789	$ 234,132	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 77,363	$ 77,388	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	538,152	538,152	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,622	13,622	6
7	Other Prepaid Expenses	36,458	36,458	7
8	Accounts Receivable (owners or related parties)	37,000	37,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 702,595	$ 702,620	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,817	14
15	Leasehold Improvements, at Historical Cost	634,813	844,929	15
16	Equipment, at Historical Cost	576,978	472,131	16
17	Accumulated Depreciation (book methods)	(802,798)	(1,420,802)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 408,993	$ 546,123	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,111,588	$ 1,248,743	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,694	$ 45,694	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,328	13,328	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,586	64,586	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,929	22,929	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	6,746	6,746	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 193,283	$ 193,283	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	41,560	41,560	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 41,560	$ 41,560	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 234,843	$ 234,843	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 876,745	$ 1,013,900	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,111,588	$ 1,248,743	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Medina Nursing Center, Inc.
Provider #0011551
12/31/2004

Schedule XV.
Balance Sheet **Schedule 17A**

Line 36 - Other Current Liabilities

	Operating	After Consolidation
Miscellaneous Current Liabilities	3,651	3,651
Due to Related Party	3,095	3,095
Total	$ 6,746	$ 6,746

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 790,109	1
2	Restatements (describe):		2
3	**Prior period adjustment for over accrual of payroll**	41,532	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 831,641	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	229,948	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(184,844)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 45,104	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 876,745	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,929,541	1
2	Discounts and Allowances for all Levels	73,158	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,002,699	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	311,942	6
7	Oxygen	6,881	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 318,823	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,902	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,561	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,406	19
20	Radiology and X-Ray	436	20
21	Other Medical Services	53,815	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 121,120	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,237	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,237	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	737	28
28a	**See Schedule 19A**	20,612	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,349	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,465,228	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	779,571	31
32	Health Care	1,531,544	32
33	General Administration	630,748	33
	B. Capital Expense		
34	Ownership	149,407	34
	C. Ancillary Expense		
35	Special Cost Centers	95,148	35
36	Provider Participation Fee	48,862	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,235,280	40
41	**Income before Income Taxes (line 30 minus line 40)****	229,948	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 229,948	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis tax payer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Medina Nursing Center, Inc.
Provider #0011551
12/31/2004

Page 19
Schedule XVII **Schedule 19A**
Income Statement

Line 28a - Other Revenue (specify):

	Amount
Vending Machine Income	7,753
Food Purchased	4,187
Loss on disposal of asset	(2,573)
Office Sales	143
Uniform Sales	6,523
Misc. Sales	271
Meal Sales	4,308
Total	20,612

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,697	1,697	$ 43,707	$ 25.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,605	6,639	143,089	21.55	3
4	Licensed Practical Nurses	5,620	6,236	110,138	17.66	4
5	Nurse Aides & Orderlies	57,661	59,981	576,721	9.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,799	1,938	20,255	10.45	9
10	Activity Assistants	2,801	2,943	29,471	10.01	10
11	Social Service Workers	4,290	4,539	64,555	14.22	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,160	29,735	13.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,136	6,626	51,860	7.83	15
16	Dishwashers	15,166	16,189	129,635	8.01	16
17	Maintenance Workers	3,768	4,066	40,337	9.92	17
18	Housekeepers	7,729	8,352	79,830	9.56	18
19	Laundry	8,084	8,608	64,328	7.47	19
20	Administrator	2,850	2,970	118,066	39.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,657	4,921	58,230	11.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,020	2,132	19,017	8.92	31
32	Other Health Ca Care Plan Coordin	1,776	2,276	43,260	19.01	32
33	Other(specify) Barber & Beauty	984	1,101	10,567	9.60	33
34	TOTAL (lines 1 - 33)	135,683	143,374	$ 1,632,801 *	$ 11.39	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	129	$ 6,058	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	990	L11, C3	44
45	Social Service Consultant	14	1,005	L12, C3	45
46	Other(specify)				46
47	Physical Rehab Consultant	Monthly	95	L10, C3	47
48	Occupational Rehab Consultant	8	413	L10, C3	48
49	TOTAL (lines 35 - 48)	165	$ 14,561		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,440	$ 93,360	L10, C3	50
51	Licensed Practical Nurses	3,424	117,127	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,864	$ 210,487		53

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100.00	$ 118,066
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,066

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin, & Glasser LLP	Accounting	$ 2,340
American Express Tax & Business S	Accounting	23,980
Duane Morris LLP	Legal	27,324
Bank One	Computer	1,318
eHEALTH Data Source	Computer	3,950
Achieve Software	Computer	8,180
Mutual of Omaha	Computer	187
Main St. Web Design	Computer	500
Computer Education	Computer	480
Information Control	Computer	1,233
Mediacom	Computer	1,199
Business Management	Computer	15,592
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 86,283

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,838
Unemployment Compensation Insurance	13,930
FICA Taxes	126,445
Employee Health Insurance	65,979
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	4,175
401(K) Plan	12,574
Employee Goodwill	7,723
Employee Uniforms	524
TOTAL (agree to Schedule V, line 22, col.8)	$ 272,188

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,500
Advertising: Employee Recruitment	6,966
Health Care Worker Background Check	
(Indicate # of checks performed 363)	528
Secretary of State	605
Miscellaneous Dues & Subscriptions	1,148
Miscellaneous License & Fees	168
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,915

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,329
Seminar Expense	3,786
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,115

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	86,283
Non-Allowable Legal Fees	(5,051)
Total (agree to Schedule V, line 19, column 8)	81,232

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8								N/A					
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,129** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,862**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,308**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	211,230	25,041	6,058	242,329	0	242,329	0	242,329
2. Food Purchase	0	172,587	0	172,587	0	172,587	-8,495	164,092
3. Housekeeping	79,830	20,582	0	100,412	0	100,412	0	100,412
4. Laundry	64,328	14,834	0	79,162	0	79,162	0	79,162
5. Heat and Other Utilities	0	0	76,630	76,630	0	76,630	0	76,630
6. Maintenance	40,337	17,422	50,692	108,451	0	108,451	0	108,451
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	395,725	250,466	133,380	779,571	0	779,571	-8,495	771,076
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	935,932	65,393	211,898	1,213,223	0	1,213,223	0	1,213,223
10a. Therapy	0	958	176,617	177,575	0	177,575	0	177,575
11. Activities	49,726	3,956	9,151	62,833	0	62,833	0	62,833
12. Social Services	64,555	0	7,358	71,913	0	71,913	0	71,913
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,050,213	70,307	411,024	1,531,544	0	1,531,544	0	1,531,544
17. Administrative	118,066	0	0	118,066	0	118,066	0	118,066
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	86,283	86,283	0	86,283	-5,051	81,232
20. Fees, Subscriptions & Promotion	0	0	10,915	10,915	0	10,915	0	10,915
21. Clerical & General Office	58,230	26,196	8,484	92,910	0	92,910	-880	92,030
22. Employee Benefits & Payroll	0	0	277,822	277,822	0	277,822	-5,634	272,188
23. Inservice Training & Education	0	0	1,983	1,983	0	1,983	0	1,983
24. Travel and Seminar	0	0	14,169	14,169	0	14,169	-2,054	12,115
25. Other Admin. Staff Trans	0	0	5,433	5,433	0	5,433	877	6,310
26. Insurance-Prop.Liab.Malpractice	0	0	23,167	23,167	0	23,167	0	23,167
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	176,296	26,196	428,256	630,748	0	630,748	-12,742	618,006
29. Total General Administrative	1,622,234	346,969	972,660	2,941,863	0	2,941,863	-21,237	2,920,626
30. Depreciation	0	0	69,164	69,164	0	69,164	17,748	86,912
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,712	1,712	0	1,712	633	2,345
33. Real Estate	0	0	39,678	39,678	0	39,678	0	39,678
34. Rent - Facility & Grounds	0	0	36,000	36,000	0	36,000	-36,000	0
35. Rent - Equipment & Vehicles	0	0	2,853	2,853	0	2,853	-877	1,976
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	149,407	149,407	0	149,407	-18,496	130,911
38. Medically Necessary T	0	0	134	134	0	134	0	134
39. Ancillary Service Cent	0	54,472	2,085	56,557	0	56,557	0	56,557
40. Barber and Beauty Shop	10,567	554	0	11,121	0	11,121	0	11,121
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	48,862	48,862	0	48,862	0	48,862
43. Other (specify):*	0	0	27,336	27,336	0	27,336	-27,336	0
44. Total Special Cost Ce	10,567	55,026	78,417	144,010	0	144,010	-27,336	116,674
45. Grand Total	1,632,801	401,995	1,200,484	3,235,280	0	3,235,280	-67,069	3,168,211

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	77,363	77,388
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	538,152	538,152
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	13,622	13,622
7. Other Prepaid Expenses	36,458	36,458
8. Accounts Receivable-Owner/Related Party	37,000	37,000
9. Other (specify):	0	0
10. Total current assets	702,595	702,620
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	3,048
14. Buildings, at Historical Cost	0	646,817
15. Leasehold Improvements, Historical Cost	634,813	844,929
16. Equipment, at Historical Cost	576,978	472,131
17. Accumulated Depreciation (book methods)	-802,798	-1,420,802
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	408,993	546,123
25. Total Assets	1,111,588	1,248,743
CURRENT LIABILITIES		
26. Accounts Payable	45,694	45,694
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	13,328	13,328
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	64,586	64,586
31. Accrued Taxes Payable	22,929	22,929
32. Accrued Real Estate Taxes	40,000	40,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	6,746	6,746
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	193,283	193,283
LONG TERM LIABILITES		
39.Long-Term Notes Payable	41,560	41,560
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	41,560	41,560
46.Total Liabilities	234,843	234,843
47.Total Equity	876,745	1,013,900
48.Total Liabilities and Equity	1,111,588	1,248,743

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,929,541
2. Discounts and Allowances for all Levels	73,158
Subtotal - Inpatient Care	3,002,699
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	311,942
7. Oxygen	6,881
Subtotal - Anciliary Revenue	318,823
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	6,902
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	57,561
18. Sale of Supplies to Non-Patients	0
19. Laboratory	2,406
20. Radiologyand X-Ray	436
21. Other Medical Services	53,815
22. Laundry	0
Subtotal - Other Operating Revenue	121,120
24. Contributions	0
25. Interest and Other Investments Income	1,237
Subtotal - Non-Operating Revenue	1,237
27. Other Revenue (specify):	737
28. Other Revenue (specify):	20,612
Subtotal - Other Revenue	21,349
30. Total Revenue	3,465,228
31. General Services	779,571
32. Health Care	1,531,544
33. General Administration	630,748
34. Ownership	149,407
35. Special Cost Centers	95,148
35. Provider Participation Fee	48,862
37. Other	0
40. Total Expenses	3,235,280
41. Income Before Income Taxes	229,948
42. Income Taxes	0
43. Net Income or Loss for the Year	229,948

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